

Medical History

NAME: _____ Date: _____

Address _____

City/State/Zip _____

Telephone: Home _____ Cell _____ Work _____

Email _____

Birth date: _____ Age _____

Occupation _____

Referred by: _____

Main Complaints:

1.Symptom _____

When did it first begin _____

What makes it better? _____

What makes it worse _____

2. Symptom: _____

When did it first begin _____

What makes it better? _____

What makes it worse _____

3.Symptom _____

When did it first begin? _____

What makes it better? _____

What makes it worse? _____

Please check any conditions or symptoms you have or have had

Serious Illnesses/Surgeries _____ Other
pertinent past conditions _____

Have you been under the care of a licensed Health Practitioner in the past
year? Yes No

If so, for what reasons _____

List of Medications and Supplements:

Medications and pharmaceutical drugs (name and dosage)

Supplements:

Family History

Please check any conditions that apply to your immediate family.

- Cancer Diabetes Allergies Heart Disease Addictions
 Alcoholism High Blood Pressure Stroke Psychological Conditions

Please check if you had any of these symptoms in the last
three months:

Head, Eyes, Ears, Nose, Throat

- Glasses Poor Vision Floaters
 Blurred Vision Red Eyes Night Vision Problems
 Glaucoma Cataracts Teeth Problems
 Teeth Grinding TMJ Dizziness Facial Pain
 Sinus Problems Recurrent Sore Throat
 Enlarged thyroid Swollen Glands Ringing in Ears
 Poor Hearing Earaches Vertigo
 Headaches Migraines Dizziness

Respiratory

- Asthma Shortness of Breath Cough Allergies Frequent Colds

Cardiovascular

- High Blood Pressure Chest Pain Low Blood Pressure Palpitations
- Swelling of hands/feet Irregular Heartbeat High Cholesterol
- Circulation

Gastrointestinal

- Abdominal/ Stomach Pain Belching Excessive Gas
- Burning Indigestion Vomiting Nausea
- Heavy after eating Sleepy (Low Energy) after Eating
- Bloating Constipation Food Particles in Stool
- Diarrhea Gallstones Candida Liver Problems

Musculoskeletal

- Neck/Shoulder Pain Upper Back Pain Low Back Pain
- Sciatica Joint Pain Fibromyalgia
- Arthritis Carpal Tunnel Knee Pain
- Tendonitis Herniated Disc Other
- Foot/Ankle Pain Hand/wrist Pain Knee Pain
- Hip Pain Limited Range of Motion

Skin and Hair

- Rashes Psoriasis Hair Loss
- Eczema Acne Fungal Infections
- Other

Psychological

- Worry Anxiety Overwhelm Insomnia
- Poor Memory Depression Sadness Lethargy
- Irritability Addictions Eating Disorders Other
- Binge Eating

Genito- Urinary

- Frequent Urination Pain on Urination Unable to hold urine
- Decreased Libido Kidney Stones
- Diabetes

General Symptoms

- Weight Gain Weight Loss Fatigue Night Sweats Muscle Cramps
- Low Immune System

Gynecology

- Irregular Periods Painful Periods PMS Fibroids
- Vaginal Discharge Breast Lumps Hot Flashes
- Vaginal Dryness Painful Sex Low Libido
- Age at Menopause_____ # Pregnancies_____
- Date of last Period_____

Diet

What do you eat on a regular basis?

BREAKFAST _____

LUNCH _____

DINNER _____

SNACKS _____

How many cups of caffeinated beverages do you drink per day?

_____ types of caffeinated beverages: coffee/tea/soda

How many cups of non-caffeinated beverages do you drink?

_____ types of beverage: herbal tea/water/milk/juice/other

How much water do you drink per day _____

Do you exercise regularly? Yes No

What type of exercise _____ length of
time _____

of glasses of alcohol per week? _____ what kind? _____

Please inform us of any other problems you would like to discuss: